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Bi-Monthly Update

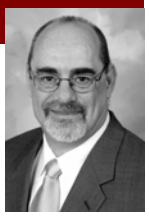
November/December 2003

The Arizona M.D. Update

A Bi-Monthly Update of the Arizona Medical Digest

A Letter from the Executive Director

Barry A. Cassidy, Ph.D., PA-C



In past newsletters, I have conveyed information to you about the agency's remarkable technological accomplishments. The last two months have been no exception. I am continually amazed and proud of the strides this agency makes while using existing technological resources.

Last month, the Board launched an expanded physician search capability on its website. The Board often receives calls from the public asking for lists of specialists in locations near them. The public can now perform a customized search for physicians with a certain specialty in a particular city or county that will bring up every licensed in-state physician who meets that criteria. While the Board does not act as a referral service, it was able to provide this option to the public.

Specialties and locations are based on information physicians provide the Board on their license application and renewal forms. Those physicians who are American Board of Medical Specialties (ABMS) certified are noted with an asterisk. If you find that one of your specialties is not listed on your physician profile, please provide that information to the Board in writing and staff will post it to the website immediately. You can mail your written requests to the Arizona Medical Board at: 9545 East Doubletree Ranch Road, Scottsdale, Arizona, 85258 or fax them to (480) 551-2704, attention Licensing.

Secondly, as you will read in this *MD Update*, the *2003-2004 Medical Directory and Resource Handbook* CD-Rom will be mailed to you in the beginning of December. To make the *Directory* easier to use, staff built an interface program which will automatically bring up the contents of the CD-Rom on your monitor in an easy-to-use format. The agency has saved a tremendous amount of money by producing the *Directory* on CD-Rom and this is one of many accomplishments that enables the Board to keep your licensing fees from increasing. For those of you who would still like a paper-bound *Directory*, they will be available for purchase ($30.00) from the Board's office.

Finally, I encourage you to check out the new website for the Arizona Regulatory Board of Physician Assistants at www.azpaboard.org. It is designed similarly to the Arizona Medical Board website and it is devoted to those topics that affect the physician assistant community most. For those of you who supervise physician assistants , this site will benefit you as well.

Happy Holidays to you and your families. I look forward to an exceptional 2004!

2003-2004 Medical Directory

It's in the mail!

Arriving on doorsteps soon, the 2003-2004 annual *Medical Directory and Resource Handbook* is your source to licensed Arizona physicians and physician assistants. Like last year, the *Medical Directory* is provided on CD-Rom. This electronic format allows for customized searches of licensees by name, location or specialty. A limited number of paper-bound copies will be available for purchase. See www.azmdboard.org for more information.

BOARD MEETING DATES

December 10-11, 2003

February 11-13, 2004

April 14-16, 2004

June 9-10. 2004

What Do You Know About Bioterrorism?

The following article is presented by the Office of Public Health Emergency Preparedness and Response, an office of the Arizona Department of Health Services.

Living with the threat of bioterrorism is the new reality, whether we like it or not. We know that we need to be doing things to prepare, but the challenge of preparing for unknown emergencies can be overwhelming. We cannot prepare for everything, but we can prepare for many things. Here are some suggestions.

Approach preparedness in bite-size pieces
If you try to do everything at once, you will get discouraged and stop. Make a plan of what needs to be done. Then do one thing on the list on a regular basis, such as every week or every month.

Prepare your office for disease surges
All offices have emergencies and infectious disease challenges. Think about how crazy your office gets during influenza season. Make a written plan with your office staff about how to triage and handle surges in patient calls and visits. Let your patients know how your office operations will change in an emergency.

Teach appropriate infection control procedures in the office
Although diagnoses are not made until the physician sees the patient in the exam room, a patient can already be infecting others on the way into the exam room. Therefore, front desk personnel, medical assistants, and nurses need to know how to use proper infection control procedures. Insist that they wash their hands before and after every patient contact. If a patient is coughing, have the patient put on a mask. For any drainage or body fluid, have the health care worker wear gloves before handling it.

Prepare psychologically
In order to take care of others, you must take care of yourself. Yet physicians routinely work on the edge of exhaustion and burnout. Get into the habit now of getting enough rest and relaxation. Know that your staff will have difficulties handling the stress of disease surges, so provide them with resources for stress management. Have information to give to families about what they can do to deal with the psychological effects of disasters. The AAP has many resources for families and pediatricians at www.aap.org.

Don't ignore personal and family preparedness
What if you had to stay at the office for several days? Do you have water? Food? A place to sleep? Consider having basic supplies at your office and in your car trunk. Would your own family have enough food and supplies to be safe without having to travel to the store? If your family is provided for, you will have an easier time caring for your patients. Suggestions for family preparedness can be found at www.ready.gov and at www.aap.org.

Be a disease detective
Astute clinicians are the first line of defense against bioterrorism. If an illness seems unusual or unexplained, call your local or state health department. If there is an increased amount of a common illness, call your local or state health department. Early detection of unusual illnesses or outbreaks can allow for early investigation and intervention. The CDC website link for terrorism www.bt.cdc.gov has links to all of the state health department websites.

Know the illnesses
The most lethal of the agents that could be used for bioterrorism are called Category A agents: Smallpox, anthrax, plague, tularemia, botulism, and viral hemorrhagic fevers. The presumed method of spread would be by aerosolization. It is hard to remember all the details of these unusual illnesses if you do not routinely see them. One way of remembering them is associating them with illnesses that you do know.

Smallpox is most often confused with chicken pox. The early rash of smallpox can be hard to differentiate from chicken pox. However, fever is a great clue. Smallpox has fever and severe prostration for 2 to 4 days before the rash appears. Chicken pox patients are rarely febrile or ill before the rash appears.

Also, smallpox rashes develop very differently from chicken pox rashes. The rash with chicken pox is very superficial, and mainly on the trunk. The vesicles scab quickly, while new vesicles show up daily for several days. The rash with smallpox is deep, firm, and less dense on the trunk than on the limbs and the face. Smallpox lesions do not keep appearing over several days. Instead, they uniformly though slowly progress from vesicle to pustule to scab.

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Avoiding False Sexual Allegations (Reprinted with the permission of *Sombrero)*

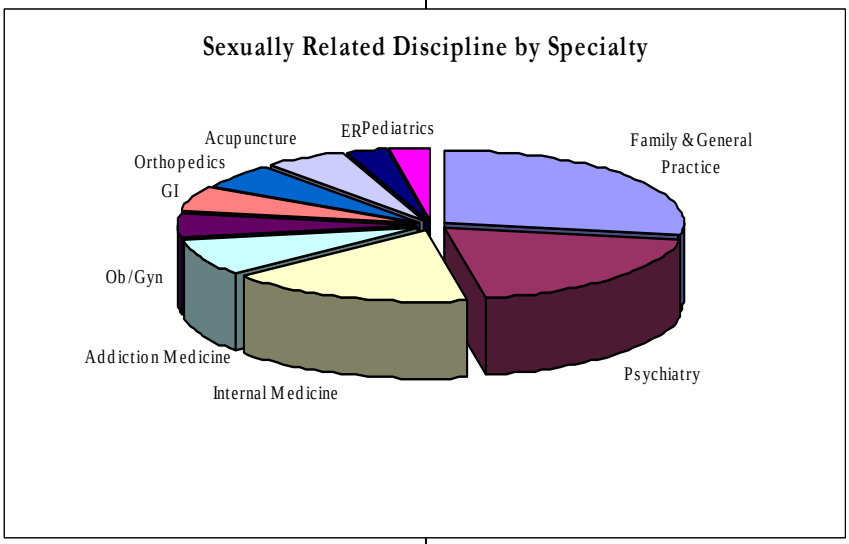
By John T. Clymer, M.D.

The incidence of patients charging their doctor with making a sexual advance is increasing.

Christine E. Dehlendorf, BSc and Sidney M. Wolfe, MD published an article titled, Physicians Disciplined for Sex-Related Offenses, in the June 17th, 1998, issue of JAMA. They reported on an analysis of sex-related orders from a national database of disciplinary orders taken by state medical boards and federal agencies. A total 567 physicians were disciplined for sex-related offenses involving patients, from 1981 through 1996. From 1989 to 1996 there was an annual increase in the number of physicians disciplined for sex-related offenses.

Of the 567 physicians, 170 had sexual intercourse with their patients, 112 had sexual contact or touching and in 285, it was not clear as to the exact nature of the sexual offense. Possibilities include sexual abuse, sexual assault, sexual encounters and sexual favors for drugs. Nowhere in the report was there a specific reference to homosexual assaults.

In a personal communication, dated August 26, 2003, Dr. Barry A. Cassidy, Executive Director of the Arizona Medical Board, reported that from 1989 to July 30, 2003, the Board has disciplined 36 physicians based on allegations of sex-related offenses. The exact nature of the sexual offenses is unknown, but could be sexual abuse, sexual assault, sexual encounters or sexual favors for drugs. The medical specialties represented were:



- Family and General Practice with 10
- Psychiatry with 7
- Internal Medicine with 6
- Addiction Medicine with 3
- Ob-gyn, GI, Orthopedics and Acupuncture with 2 each
- ER and Pediatrics with 1 each

None of the Arizona physicians was female.

Aside from discipline by the Board, the physician is liable for criminal charges. Sexual assault is a felony. In all cases the victim is referred to the police for possible criminal charges. The decision of whither a case is pursued is up to the County Attorney.

These are serious offenses. What can a physician do to avoid allegations of this type? First is to know your patient and second is to know yourself.

Knowing and understanding your patient involves awareness and knowledge about personality types. Psychiatrists call them personality disorders. There are 10 in all and they first begin to appear when the individual is a teenager. They are life long, not amenable to any type of treatment, and lead to significant distress (impairment) in social, occupational or other important areas of functioning.

A patient showing up in a medical practice with one of these disorders can be very difficult for the attending physician to manage in an appropriate fashion. Of the 10 disorders, most of the "problem" patients seen in a medical practice probably have one of the following five:

- **Paranoid:** These people are distrustful and suspicious, believing that people's motives are malevolent.
- **Antisocial:** These people have a disregard for, and violate the rights of others. Many criminals fall into this category. At one time or another, they have been to several different physicians. They lie in a most convincing fashion. They have a real knack in targeting a person's soft spot.

(continued on page 4)

(Sexual Allegations—continued from page 3)

- **Histrionic:** These people need to be the center of attention, frequently using physical appearance to do so. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior. They consider relationships more intimate than they really are. They are theatrical and have exaggerated expressions of emotions.

- **Dependent:** These people have difficulty making everyday decisions, and need others to assume responsibility for most major area of his/her life. They have difficulty expressing disagreement with others and go to great length to obtain nurture and support from others.

- **Borderline:** These people make frantic efforts to avoid real or imagined abandonment. They have a long pattern of intense interpersonal relationships that alternate between extreme idealization and devaluation. They are impulsive in areas of spending, sex, substance abuse, reckless driving and binge eating. There is recurrent suicidal behavior or self-mutilation. They have inappropriate intense feeling of anger or difficulty controlling anger. They may have brief stress-related paranoid ideation and brief dissociative symptoms resembling a psychosis.

For a physician, knowing thyself is the best way to reduce the risk of being the object of false sexual allegations. How does one do this? Here are 12 suggestions:

1. Learn about the personality disorders and constantly try to identify those people inside and outside your practice that might fit one of the above categories. This is good practice and this can help you to more quickly spot one of the above categories.

2. Have a chaperone – same sex as the patient - with you when you examine the patient. This is also true when you just meet with a patient at your office outside regular hours or at any location other than a hospital. Years ago I would take along my wife as chaperone.

3. Be mindful where and how you touch a patient. A handshake is all right. Arm around the shoulder? Questionable. Embrace? I would say not. If the patient embraces you, make it brief, then break and say something like: "I am not one to routinely embrace my patients. I prefer to shake hands."

4. Does a particular patient arouse erotic feelings in you? Do you have sexual fantasies or dreams about her/him? Careful. When having subsequent encounters with this patient, be very proper. You may want to address him/her as "Mr." or "Miss/Mrs. Jones" rather than by their first name. Should your erotic feeling continue when you see the patient in subsequent visits, you may want to step down as her/his physician. The patient may be already somewhat aware of your feelings and, if acted upon, this could lead to a disastrous consequence.

5. Do not make any sexually suggestive remarks and this includes sexual jokes.

6. When this kind of remark comes from the patient, reply by saying that you always speak and act appropriately with your patients and you would hope they are always appropriate with you.

7. In taking a history from patients, if you will be asking personal or intimate questions, tell them in advance and add that if they do not wish to reply, you will respect their decision. The chaperone should be present when you say this and also when you ask your questions.

8. Keep your "cool" at all times. Some patients, even those without a personality disorder can be difficult to treat. They may be noncompliant or distrustful. When you are stymied, don't react hastily or angrily. The patient, angry in turn, could vengefully be tempted to file a false charge of harassment.

9. If you decide it is necessary to step down as the patient's physician, be sure to comply with all legal and ethical requirements. Those physicians who are employed, work in a group or in a HMO setting, need to consult with the medical director as to how to cope with a patient causing difficulties.

10. Once you decide and have told the patient of your decision, there is no turning back. Be prepared for the paranoid patient to accuse you of ulterior motives. The antisocial patient will try to make you feel guilty. The histrionic patient may loudly say: "We were getting along so famously!" The dependent patient will want to cling. Or say: "I so desperately need you!" The borderline patient will become enraged and make vague references to suicide.

11. Be prepared for attempts to come back as a patient. These may include suddenly appearing in your office wanting to speak to you, "for just a minute", writing letters to you, calling you on the phone, leaving messages on your answering machine or with your service. I feel all attempts require a brief reply by the physician, not a staff person, such as: "The reasons for my discharging you as a patient still stand."

12. Remember you are most vulnerable to slips in judgment when you are depressed, fatigued, under stress, in financial straits or "using" drugs or alcohol.

Note: My special thanks to Barry A. Cassidy, Ph.D., P.A.-C, Executive Director of the Arizona Medical Board for so promptly providing the data on Arizona physicians.

John T. Clymer, M.D. is a retired psychiatric physician, residing in Tucson, Arizona

Question of the Month

Q. If I send lab reports or x-rays to a physician in another state for evaluation, does that physician need to be licensed in Arizona?

A. Yes. Any physician practicing medicine on a patient in Arizona, must be licensed in Arizona (See A.R.S. §32-1401(21) for the definition of practice of medicine.) The only exception to the licensing requirement is found in A.R.S. §32-1421(B), which states that "This article does not apply to any doctor of medicine residing in another state, federal jurisdiction or country who is authorized to practice medicine in that jurisdiction, if he engages in actual single or infrequent consultation with a doctor of medicine licensed in this state and if the consultation regards a specific patient or patients.

Tips for using your 2003-2004 Medical Directory and Resource Handbook CD-Rom

Last year, the Arizona Medical Board disseminated a *Medical Directory* containing physician laws and a listing of licensed physicians on CD-Rom to all licensed in-state physicians. This year, you will again receive your *Medical Directory* on CD-Rom. However, several enhancements have been made to this version that will simplify your searching experience. Use the following steps to guide you through the *2003-2004 Medical Directory and Resource Handbook*:

1. **Insert the CD-Rom into your computer.** An Auto Run mechanism will automatically bring up the contents of the *Directory* on your screen.

2. **Choose what you want to see.** A menu appears and you can opt to view an electronic edition of the *Directory*; a physician listing in an Access, Excel or Text format; links to the Arizona Medical Board or Arizona Regulatory Board of Physician Assistants websites; or download a free version of Adobe Acrobat if you don't already have it installed on your computer.

3. **Search within the electronic edition.** When you open the electronic version, scroll down to the second page. There, you will find a table of contents. Each item on the table of contents is hyperlinked. Click on the hyperlink to find specific areas in the document you are interested in. For example, you can find letters from the Chairmen of the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants, agency contact information, and the laws governing medical practice in Arizona.

4. **Exit when your finished.** Just click on the exit tab when you are finished viewing the *Directory*. If you need to get back into the CD-Rom, either re-install the disk or access the data on your CD Drive.

Remember: All physician data was gathered in November 2003. Any changes made to physician addresses, specialties, etc. after November 2003 are not captured on this *Directory*. For the most current physician information, consult the Arizona Medical Board's website at www.azmdboard.org. All information on the website is updated daily.

(Bioterrorism—continued from page 2)

Inhalational anthrax would be most likely confused with influenza or community acquired pneumonia. The chest X-ray often shows a widened mediastinum. Infiltrates or pleural effusions may or may not be present. In 50% of patients there is also meningitis. Think anthrax if a patient has respiratory distress that is not improving, or if an ill patient has gram-positive rods in their blood or spinal fluid.

If *plague or tularemia* bacteria were released as aerosols, they would cause cases of pneumonia. The patients would be extremely ill, and often would be bacteremic. In most cases a diagnosis of plague pneumonia or tularemia pneumonia cannot be made simply by chest X-ray (although tularemia can cause hilar adenopathy). Think of unusual pathogens if a patient is not improving as expected with standard treatment.

Botulism presents as a descending flaccid paralysis in an afebrile patient who is very alert. The cranial nerves are the first to be affected. There would be eyelid droopiness, and trouble swallowing and speaking. Remember the "four D's:" Dysconjugate gaze, dysphonia, dysarthria, and dysphagia. Descending paralysis that affects the diaphragm requires intubation for weeks to months. In contrast, Guillain-Barré syndrome and tick paralysis usually present as an ascending flaccid paralysis.

Viral hemorrhagic fevers cause hemorrhage, DIC, and diffuse vasculitis. If you cannot explain a febrile, hemorrhagic illness, consider VHF in the differential diagnosis. Strict infection control measures are essential in these patients.

Worried? Call the health department

County, tribal and state health departments have resources to assist clinicians. The Arizona Department of Health Services (ADHS) has a website at www.hs.state.az.us with bioterrorism and emergency preparedness information, links to educational sites, and access to county health websites. The ADHS Office of Public Health Emergency Preparedness and Response can be reached at 602-364-3289.

QUALITY ASSURANCE – MORE THAN A PAPER REVIEW

When Arizona Medical Board Executive Director Barry A. Cassidy, Ph.D., P.A.-C started the agency's first ever Quality Assurance Division, his vision was to provide more than a standard paper review of information going to the Board. "This was our chance to make a cohesive presentation of pertinent information to Board members. Major case developments should be brought to the surface quickly with supplemental, confirming evidence available as a resource," he said.

Materials sent to each Board member for their bi-monthly meetings have been known to total in the thousands of pages. Board members are often bombarded with medical consultant opinions, review committee opinions, and technical evidentiary documents. "What I wanted was an oversight team," said Cassidy. "I wanted someone who could condense all this information into one comprehensive report."

Cassidy's first move toward a Quality Assurance Division was to appoint Barbara Kane, a senior member of the agency's enforcement team with years of investigative and medical malpractice analysis under her belt. "I see my role as two-fold," said Kane. "In addition to explaining case rational to Board members, I also have a responsibility to provide complainants with the agency's rational for either pursuing an investigation or dismissing a case because there was no statutory violation."

The Arizona Medical Board receives over 1,000 complaints each year. "The people who file those complaints have invested considerable time and emotion to inform us of their concerns," Kane continued. "We have an obligation to address those concerns."

While the program is still in its infancy, it has received generous praise from Board members, the public and physicians. "This is just the start of a new and more advanced level of communication," said Cassidy.